The emotional stress of the preoperative patient

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The emotional stress that the patient endures preoperatively can have a profound effect on the course of anesthesia. The anesthetist can alleviate some of this stress by understanding the patient's fears and anxieties, and by giving the patient emotional support and reassurance.

The purpose of this article is to discuss the emotional stress the adult patient undergoes before surgery, and the means by which the individual copes with this stress. Every anesthetist is aware of the cardiovascular and endocrine responses associated with emotional stress. But not all are aware of the anxieties aroused about death, not waking up, passivity, mutilation, and the fear of uncontrolled behavior under anesthesia, among others.

Since such anxieties and fears can adversely affect the course of anesthesia and even retard the recovery period, it is important that the anesthetist recognize them as such. With adequate preoperative preparation by the anesthetist and surgeon, many of the patient's fears can be allayed.

The development of an individual's emotional and cognitive factors influence the psychological and intellectual resources available to deal with a crisis. And, through the development and integration of these factors, a strong ego is established which plays a significant role in determining one's adaptive abilities under stress. Consequently, one of the most important roles of this strong ego is being able to deal effectively with stress, and to deal rationally, through reason, with the requirements of reality.

One of the most important influences on the person's coping ability is the previous experience he or she has had with stressful situations. The individual's response to surgery and anesthesia will depend on what the illness means to the patient, and what the previous experience has been with doctors, hospitals, surgery, and anesthesia.

The many stresses the patient encounters in the hospital will be the same type of stress-evoking situations experienced as a child. Therefore, the patient's ability to cope in this situation will be influenced by his/her earlier adaptive ability to these stresses. As a result of the individual's attempt to adapt in earlier life, defenses evolve. These defenses, in themselves, are not necessarily pathological but rather are developed to manage anxiety, aggressive impulses, hostilities and resentments, and are essential in maintaining one's normal psychological well-being. Some of the more common mechanisms used by the surgical patient are anxiety, denial, mild temporary dissociation, and regression.

Anxiety is a common affect aroused when there is a threat to the integrity of one's self. It is associated with all surgery. The anxious patient has a pervasive feeling of dread which arises in...
anticipation of danger rather than as its result. This affect is multifactorial and aroused by a fear of:

1. losing control of one's body.
2. pain and mutilation.
3. loss of love and affection.
4. the unknown.
5. death.

Some may feel these fears are neurotic, but whatever, they are realistic to the patient and should not be minimized by the anesthetist, since such anxiety may have a negative effect. Not only is the quantity of preoperative medication and the anesthetic agent increased, but there is also compelling evidence that emotions, and anxiety in particular, increase cardiac work and decrease cardiac reserve, leading to coronary insufficiency and heart failure in the diseased heart. In these cases, the patient denies what is perceived or felt, either by disowning its existence or altering reality so it is no longer painful. At times, it is a useful mechanism protecting the patient against overwhelming feelings. But, at other times it can interfere with necessary treatment and care.

In the event that anxiety overwhelms the patient, mild temporary dissociation, which is similar to denial, may be necessary. In dissociation, one is able to isolate his or her emotions when dealing with distressing situations, by temporarily separating one or more components of the personality from the rest. It is particularly common in surgical procedures with emotional implications, as in mastectomies, amputations, colostomies, hysterectomies, and cardiac surgery.

Dissociation allows the patient time to gather other coping mechanisms and to assimilate reality. As such, it is a self-protective response to stress, and emotionally, it is less distressful to isolate what it is that arouses the anxiety. Dissociation may also take the form of depersonalization and estrangement, where familiar objects or the self may seem strange and unfamiliar. These periods of estrangement and depersonalization have been reported by patients in the recovery room and intensive care unit. They may complain that everything looks strange and different. Further, the patient may feel that he/she is unreal and that it cannot be he/she who is actually seeing, hearing and feeling.

A defense necessary for successful
recovery from surgery is regression. In a regressed state, one assumes a less mature state of behavior which has been previously outgrown. In spite of this immaturity, temporary regression should be encouraged since it is less demanding on the patient, consequently reducing stress and increasing security. For the most part, patients are sufficiently secure and trusting enough to be able to surrender their independence and rely on the medical personnel for their needs.

Preoperative depression may be present in anticipation of surgery. The patient may appear withdrawn and hostile, and it may even be difficult for the anesthetist to have a meaningful conversation with the patient. It is not unusual, especially in the female, to be depressed over the loss of integrity of the body, since the skin will be cut, never to be the same again.

Acute depression may be present in anticipation of the possible loss of a valued body part or function, and after surgery with the actual loss. The extent of the reaction of the patient to this loss will be determined by the part of the body affected and its meaning to the patient.

For many years, it had been thought that one could ignore the psychological responses of the patient under anesthesia. But some postoperative depression and anxiety has been attributed to the effects of remarks made during surgery. Utilizing the technique of general anesthesia combined with muscle relaxants (where there is consequently a lighter plane of anesthesia maintained), researchers have found that patients perceive remarks made while anesthetized.

Those patients studied were able, under hypnosis, to recall statements made in the operating room, most readily those remarks indicating the patient was in danger. The subsequent depression and anxiety was alleviated through hypnosis and verbalization.

The anesthetist is in a unique position to help ease the patient's anxiety and fears preoperatively. One would be remiss as an anesthetist if he or she did not visit every patient preoperatively. This visit is the appropriate time to discuss with the patient the type of anesthesia to be administered and the reason for that particular choice. Furthermore, by involving patients in the actual discussion, they will feel that they have a sense of control over their lives, although the final decision remains with the anesthetist.

The visit should include inquiries into the patient's previous experience with anesthesia and any complications which may have resulted. The patient should be encouraged to ask questions about the anesthesia. Most importantly, the anesthetist should ask the patient if he/she has any fantasies about what may happen under anesthesia. These fantasies often lie dormant, only to be reactivated under stressful situations.

It is imperative that the pre- and postoperative procedures be explained, from the night before surgery to the time of recovery. This should include information about the recovery room environment, and the pain, if any is to be expected. The patient should also be informed that medication is available for this pain. It has been found that those who received information prior to surgery about pain and what to expect, required less medication in the recovery room than those who did not receive this information.

When the patient is to go to the intensive care unit postoperatively, the anesthetist should explain the nature of the unit and its procedures to him or her. The intensive care unit environment may provide the patient with a sense of security, but it also may increase emotional stress and thus retard recovery. The intensive care unit surroundings, with its continuous activity and sense of disaster, may be frightening and become an additional stress for the conscious patient.

In the operating room, the anesthetist should make every effort to shield the patient from unnecessary external stimuli, particularly noise. At the same
time, the surgeon should be discouraged from exposing and examining the patient before induction. This can be particularly stressful for the apprehensive patient, since not only is the patient in a helpless, vulnerable position but anxiety may again be aroused before induction of anesthesia.

Generally, most patients with emotional support, reassurance, and the aid of defenses, are able to withstand the emotional stress of surgery and anesthesia. But, those who are vulnerable—because of excessive anxiety due to inadequate coping mechanisms—should be identified and counseled before surgery, when possible. However, recognizing a patient with anxieties and fears is not easy and dealing effectively with them when recognized is even more difficult. 14

The most effective approach to reduce recognized anxiety in the patient is to encourage communication. It should be emphasized that considerable patient anxiety is suffered needlessly because of misconceptions and distortions due to a lack of knowledge and understanding of what will happen under anesthesia.

It is essential that the anesthetist be able to empathize with the patient and be aware of the importance of the patient’s psychological, as well as physical, well-being. It can only have positive effects if the anesthetist thinks of the patient, not as a “gall bladder” or “hysterectomy” but as a unique human being possessed of the same anxieties, feelings, and fears common to every man and woman.

REFERENCES

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